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Child Developmental History Record

1. Preliminary Information

- Child's name: _____ Birthdate: _____ Age: _____ Race/Ethnicity_____
- Person(s) completing this form: _____Today's date: _____
- Relationship to this child:_____
- Address:_____
- Telephone:_____ E-mail:_____
- Child's school:_____ Grade:_____
- Reason for seeking help at this time (i.e., What is the problem or issue for which you are needing assistance with?_____
- What kind of services are you seeking? (for example, therapy, psychological testing, parenting consultation) _____
- Who referred you to my practice:_____
- Name of your child's pediatrician:_____

2. Family Composition

- Mother's name: _____ Birthdate:_____ Home phone: _____
  Address: _____
  Currently employed: __ No _ Yes, as: _____
  Last grade completed in school:_____
- Father's name: _____ Birthdate: _____ Home phone: _____
  Address: _____
  Currently employed: __No __Yes, as: _____
  Last grade completed in school:_____
- Parents are currently __ Married __ Divorced __ Remarried __ Never married _ Other: _____
- Child's custodian/guardian is: _____
- Stepparent's name: _____Birthdate_____ Home phone: _____
  Address: _____
  Currently employed: _ No _Yes, as: _____
- Any other guardian?_____Birthdate_____ Home phone: _____
  Address: _____
  Currently employed: _ No _Yes, as: _____
- Please list all immediate family members (brothers, sisters, ½ or step-siblings, step-parents): _____

- Has the child experienced any deaths in the family or other similar losses:_____
  _____

3. Developmental History

Pregnancy and delivery

- Where was your child born?_____
- Was your child adopted?_____
- Prenatal medical illnesses and health care: _____
- Were cigarettes, alcohol or other drugs used during pregnancy?_____
- List any prescribed or over the counter medications taken during pregnancy (include vitamins)_____
- Length of pregnancy_____
- Was the child premature? _____ Weight and length at birth: _____ _____
- Mother's age at the time of the birth of this child_____
- Please list any complications that occurred during the pregnancy

  ___High blood pressure
  ___Toxemia
  ___Emotional problems
  ___Anemia
  __ Hospitalizations during pregnancy_____
  ___Maternal injuries_____
  ___Other_____

- Any problems or complications at birth?_____
- Did baby cry immediately?_____
- Did baby need help with breathing?_____
- Child's and mother's condition at birth:_____

The first few months of life

- Breast-fed?_____ If so, for how long?_____
- Any allergies? _____
- Were there any difficulties during the baby's first few months? If yes, please check and describe:

  _____feeding _____sleeping _____alertness _____activity level
  _____movement _____jaundice _____Other:_____

- Sleep patterns or problems: _____
  _____
- Personality: _____
  _____

Developmental Milestones: At what age did this child do each of these?

- Sat without support: _____
- Crawled:_____
- Walked without holding on: _____
- Ate with a fork:_____
- Stayed dry all day:_____
- Stayed dry all night: _____
- Did bed-wetting occur after toilet-training? Yes No If yes, until what age?_____
- Did bed-spoiling occur after toilet training? Yes No If yes, until what age?_____

- Were there any medical reasons for bed-wetting? Yes No If yes, please describe
  _____

- Dressed self completely: _____
- Age when child said first word understandable to strangers: _____
- Age when child spoke 3 or more word phrases understandable to a stranger: _____
- Any speech, hearing, or language difficulties:_____

- During the child's first four years, were there any difficulties in the following areas?

Eating	Yes	No
Motor Skills	Yes	No
Sleeping too much	Yes	No
Sleeping too little	Yes	No
Temper tantrums	Yes	No
Failure to thrive	Yes	No
Separating from parents	Yes	No
Excessive Crying	Yes	No
Colic	Yes	No

Temperamental factors:

- Please describe your child's temperament as a toddler/preschooler:

High Activity level, unusually active	Yes	No
Impulsive	Yes	No
Fearful/Inhibited	Yes	No
Anxious in new situations or new people	Yes	No
Accident prone	Yes	No
Short attention span	Yes	No
Irritable	Yes	No
Poor adaptation to change	Yes	No
Colic	Yes	No
Frequent temper tantrums	Yes	No
Eating Problems	Yes	No
Sleep Problems	Yes	No
Clumsiness	Yes	No
Rigid, tense instead of cuddly	Yes	No

- Is there anything else that may describe your child as a toddler:
  _____

Environmental Risk Factors:

- Did your child experience any of the following:

Significant loss or separation from a loved one	Yes	No
Sexual Abuse	Yes	No
Physical Abuse	Yes	No
Emotional Abuse	Yes	No
Violence in the family	Yes	No
Neglect	Yes	No
Extreme family stress	Yes	No
Economic problems/financial stress	Yes	No
Poor diet	Yes	No
Exposure to heavy metals (lead)	Yes	No

- Were there any other traumas during the child's childhood? If yes, please describe:

_____
_____

4. Health

- List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Did your child experience any of the following:

Allergies	Yes	No
Asthma	Yes	No
Ear infections	Yes	No
Encephalitis	Yes	No
Meningitis	Yes	No
Fainting Spells/blackouts	Yes	No
Careless accidents/frequent falling	Yes	No
Frequent emergency room visits	Yes	No
Broken bones	Yes	No
Hospitalized for any reason	Yes	No
Loss of consciousness	Yes	No
Seizures	Yes	No
Speech problems	Yes	No
Anemia	Yes	No
Heart problems	Yes	No
Breath holding spell	Yes	No
Coordination problems	Yes	No
Staring spells	Yes	No
Swallowing/sucking problems	Yes	No

- Has the child ever been on long-term medication (more than 6 months)? Yes No
  If yes, please explain_____

- Has this child ever had a neurological exam? Yes No
  If yes, please explain_____

- Has your child had x-rays or special x-rays such as: CAT Scan_____ MRI_____ Other_____

- Has your child ever had a psychiatric or psychological exam? Yes No
  If yes, please explain_____
- Has this child ever seen a psychologist, counselor or therapist for counseling? Yes No
  If yes, please explain_____
- Describe your child's **current** sleeping patterns:_____
- Do you have concerns about your child's sleeping?_____
- Describe your child's **current** eating habits:_____
- Do you have concerns about your child's eating or feeding habits?_____
- Has your child had any recent weight gains or losses?_____
- Please list any current medications:_____
- Please provide the name of your child's current pediatrician:_____
- Any other service providers past or present (OT, PT, Speech/Language)?_____
- Date of last vision exam: _____ Any pertinent results from the exam?_____
- Any difficulties with hearing skills?_____

5. Residences

- Homes

Dates From	To	Location	Reason for moving	With whom	Any problems?

Residential placements, institutional placements, or foster care (if applicable)

Dates From	To	Program name or location	Reason for placement	Problems?

6. Educational Experiences

- School (Name, district, address, phone) Grade Age Teacher

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

- Please indicate if any of the following are applicable:

Failed any grades	Yes	No
Retained in grade	Yes	No
Skipped a grade	Yes	No
Took special classes	Yes	No
Evaluated by school	Yes	No
Labeled by school	Yes	No
Had learning difficulties	Yes	No

Received tutorial assistance	Yes	No
Suspended from school	Yes	No
Reading problems	Yes	No
Learning the alphabet names	Yes	No
Learning alphabet sounds	Yes	No
Initial decoding problems	Yes	No
Reading fluency problems	Yes	No
Reading comprehension problems	Yes	No
Arithmetic problems	Yes	No
Writing problems	Yes	No
Handwriting problems	Yes	No
Alphabet writing problems	Yes	No
Spelling problems	Yes	No
Performance was variable or unpredictable	Yes	No
Told that child was not achieving up to potential	Yes	No
Does the child dislike school	Yes	No

- Did any other significant events occur during school? Yes No

- If yes, please describe:_____
  _____

- Describe the child's academic progress thus far:_____
  _____

- Has your child ever had an Individualized Educational Plan (IEP)?_____

7. Current Emotional/Behavioral Functioning

- Describe your child's behavior by circling the frequency:

Happy	rarely	sometimes	often
Sad	rarely	sometimes	often
Angry	rarely	sometimes	often
Shy	rarely	sometimes	often
Restless	rarely	sometimes	often
Temper	rarely	sometimes	often
Stubborn	rarely	sometimes	often
Immature	rarely	sometimes	often
Jealous	rarely	sometimes	often
Tantrums	rarely	sometimes	often
High Activity level	rarely	sometimes	often
Does not want to leave parent	rarely	sometimes	often
Cooperative	rarely	sometimes	often
Affectionate	rarely	sometimes	often
Aggressive	rarely	sometimes	often
Indifferent	rarely	sometimes	often
Cries often	rarely	sometimes	often
Withdrawn	rarely	sometimes	often
Plays alone	rarely	sometimes	often
Plays with other kids	rarely	sometimes	often
Difficult to discipline	rarely	sometimes	often
Not afraid of strangers	rarely	sometimes	often
Poor attention/distractible	rarely	sometimes	often
Unusual fears or routines	rarely	sometimes	often

- Is your child more anxious or shy than other children his/her age?_____

- Is your child more worried than other children his/her age?_____

8. Recreational

- List hobbies, sports; recreational, TV, and toy preferences; etc.: _____
_____

- Does the child have problems relating to or playing with other children?_____

- Does the child fight frequently with playmates?_____

- Does the child prefer to:

Play with family only?	Yes	No
Play alone?	Yes	No
Play with older children?	Yes	No
Play with same age children?	Yes	No
Play with younger children?	Yes	No

- Does the child have difficulty making friends?_____

- How much video/screen time does your child consume on a weekday? _____

- How much video/screen time does your child consume on a weekend day?_____

- What is your child good at?_____

8. Current Home Environment

- Who resides in the home currently?_____

- How would you describe your home environment**?**_____

  _____

- Are there any firearms in the house?_____

  If yes, please describe how these are stored:_____

- Approximately, how many hours does your child spend on digital media (i.e., "screens:" TV, computer, IPAD, phone, video games)? Weekdays_____ Weekends_____

9. Extended Family History

- Has any individual in the child's immediate or extended family ever been diagnosed with the following:

  Learning Disabilities? If yes, please list who:_____

  AD/HD? If yes, please list who:_____

  Epilepsy/Seizures? If yes, please list who:_____

  Anxiety? If yes, please list who:_____

  Depression? If yes, please list who:_____

  Manic-Depression? If yes, please list who:_____

  Substance abuse? If yes, please list who:_____

  Any other diagnosis? If yes, please list who:_____

10. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

_____

_____

_____

_____

Thank you for your time and attention in completing this form!